TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, October 11, 1893.

CHARLES K. BRIDDON, M.D., Chairman, *pro tem.*

LATERO-INTESTINAL ANASTOMOSIS FOR NEOPLASM.

DR. L. A. STIMSON presented a man, fifty-seven years of age, who was admitted to the New York Hospital July 15, 1892, with the history that for some years he had been suffering more or less from chronic constipation, and for about three months before admission from attacks of severe pain in the left side of the abdomen, to which little by little was added considerable abdominal distension. For the last four weeks the bowels have moved only by enema. About two weeks before the speaker saw him he entered another hospital in the city because of abdominal distress, and about a week before he left there and entered the New York Hospital he vomited dark-colored matter and his general condition deteriorated markedly. When the reporter saw him his condition seemed very serious. The pulse was 120, the temperature 103°; there was persistent vomiting and belching; he was unable to retain food, and had had no movement from the bowels for a week. The history pointed to structural obstruction of the bowel on the left side, probably in the sigmoid flexure, and his condition was so low that it was deemed advisable at first only to relieve the obstruction by making an artificial anus in the right groin, opening the cæcum. This was followed by gradual improvement in his symptoms and condition. On August 10, nearly four weeks later, his condition was so far improved that it seemed proper to attempt permanent relief of the intestinal obstruction which was believed to be located in the sigmoid flexure. The deposit of fat in the abdominal walls was too great to permit satisfactory physical examination. A free incision was made along the left linea semilunaris, and the sigmoid flexure was found to present a solid mass about the size of the fist, presenting the general appearance which we are

accustomed to see in carcinoma of the intestine. This mass was so large and so firmly bound down to the posterior parietes that it was thought inadvisable to attempt its removal, and he contented himself with an anastomosis between the left portion of the transverse colon and the upper end of the rectum.

It was made without plates, by long, free incisions, binding the edges of the two orifices together, and was satisfactorily accomplished. The artificial anus in the right iliac region was retained, of course. Primary union took place, and on August 28, eighteen days after anastomosis, the man passed a large-formed movement per rectum, and this was followed by daily movements. On September 9 he closed the opening in the right side, and on October 2 the man left his bed, and on the 15th left the hospital. Since then he has enjoyed good health, as his appearance indicates. He is a professor of music, and is regularly engaged in his professional duties. He says that he feels better than he has for years. Manual examination of the abdomen reveals nothing, the walls being very thick.

The striking point in the case is that the man should have been so well and so comfortable for fifteen months after the operation with the epithelioma, which was evidently the nature of the tumor, still remaining. Whatever the future may bring, his present condition gives no indication of the presence of the malignant growth in the sigmoid flexure. Of course, it is possible the disease is not cancer, but it presented all the ordinary appearances of cancer.

In connection with that case he referred to another in which the same diagnosis was made. He exposed and recognized a tumor within the abdomen of the man, supposed to be malignant disease of the transverse colon, so extensive and so matted to other parts by adhesions that he refrained from further interference and closed the wound.

As there were no obstructive symptoms, lateral anastomosis was not done. A few months afterward the patient returned to the hospital with symptoms of obstruction. One of his colleagues opened the abdomen and established lateral anastomosis. More than two years have since elapsed, and the man is still in good health, although he has lately shown some symptoms of obstruction.

Such results indicate that the field for lateral anastomosis should not be restricted to cases in which removal of the cancer is impossible, but that the average survival may perhaps be greater if it is made use of also in cases in which removal is difficult although practicable.

ARTHROTOMY FOR IRREDUCIBLE DISLOCATION OF THE ELBOW.

Dr. STIMSON presented a second case, a lad of nine years, who was admitted to the New York Hospital October 3 last, having come from the country with the history that the previous day he had fallen from a hay cart and had suffered dislocation of the left elbow. A physician gave him ether and attempted to reduce the dislocation, but the attempt failed. Another attempt was made without ether, and then his parents brought him to the city. Here again, before the speaker saw him, an attempt was made by the house-surgeon to reduce the dislocation under ether, and that failing he was sent for. On examination it was evident that there was a dislocation of both bones of the fore-arm backward at the elbow.

The lower end of the humerus could be felt in the fold of the joint, entirely subcutaneous and apparently denuded of all its attachments to the soft parts. No radial pulse could be felt, and there were certain signs of either defective innervation or loss of power in the muscles which move the wrist. The boy was anæsthetized, and when it became evident that reduction could not be effected in the ordinary way, he at once proceeded to expose the dislocation by an incision of which the scar was evident upon the inner side of the joint. On making this incision in the skin, carrying it down to the fascia, the lower end of the humerus came in sight entirely stripped of all its attachments to the soft parts, and presenting through a longitudinal slit in the enveloping fascia. Across the lower end of the humerus, between the capitellum and the trochlea, ran the uninjured brachial artery. The tendon of the biceps lay behind the external condyle. The brachialis anticus was torn. By passing a blunt hook over the outer side of the lower end of the humerus and engaging it under the tendon of the biceps, he was able to bring back that tendon and the associated soft parts, and then brought back the soft parts on the inner side, united the fascia by suture and closed the wound.

The wound healed primarily, and three weeks after the operation the arm was taken out of the plaster splint and the boy was instructed to use it. The gain in function has gone on steadily until at present there is complete extension, flexion within a right angle, complete pronation and partial supination. The case is interesting because of the extensive dislocation of the bone and denudation of the lower end of the humerus, with complete escape of the median nerve and the brachial artery.

HYSTERICAL BLUE ŒDEMA.

Dr. A. J. McCosh presented a patient with the following history: Age, twenty-eight. Married at age of twenty-five. Had always been a healthy girl. Her mother was a nervous woman. Nine months after marriage her husband was killed in a railroad accident and she was much prostrated by his death. In August, 1891, while in a swimming match, she was seized with cramps and was carried out of the water. Three weeks later she began to complain of sharp shooting pains in left breast. A few days later she had a convulsion. For the next three months she continued to have convulsions averaging two a week, and during this time the breast increased in size and was very painful. She then went into a hospital and an opening was made into the breast February, 1892, and she says pus came out, although the hospital report says no pus was found. In April, 1892, she entered another hospital, and from a photograph taken at that time it appears that the left breast was very much enlarged, appearing swollen and œdematous, soft and cyanotic. On the left hand and forearm are the same œdema and bluish color. The œdematous parts are cold to the touch. The breast is very hyperæsthetic and this extends over the shoulder. Anæsthesia of the anterior surface of left arm and forearm. During the next two months she had occasional convulsions, and they often were followed by a local paralysis and areas of anæsthesia on arm, hand, forearm, and leg, loss of speech and hearing.

She then left the hospital.

The next account of her is in May, 1893, when she entered another hospital on account of a "painful growth in left breast," and here the remaining portion of breast was removed. (She says it was removed in thirteen operations.)

In July, 1893, the right breast was removed in another hospital, supposed to be a malignant growth.

Dr. McCosh first saw the patient two months ago, when she came to the Presbyterian Hospital complaining of pain in the cicatrix of the right breast. In the centre of the cicatrix was an oval, deep ulcer, two inches long, filled with unhealthy looking granulation tissue. As the diagnosis of sarcoma had been sent with the patient, I presumed it was a recurrence and excised the ulcer. On microscopical examination there was nothing but granular and inflamed tissue. She has been in the hospital ever since and has had a number of the blue œdematous spots on arms and legs, some of which

have broken down, as is now the case with one on the arm. She has had no convulsions or paralysis, but has large areas of complete anæsthesia to pain and touch on back, arms and legs. A part of the history has been published by Drs. Shaw and Duryea in the *Brooklyn Medical Journal*, May, 1893.

PLASTIC OPERATION FOR RESTORING THE BRIDGE OF THE NOSE.

Dr. FRED. LANGE presented a woman about thirty-five years of age in illustration of the method he had practiced for reconstruction of the bony bridge of the nose. The method consisted in making a vertical incision beginning on the upper part of the forehead and extending almost to the apex of the nose, the soft parts being then dissected back on both sides sufficiently to lay bare a small area of periosteum, from which the flap was taken with a thin shell of bone, corresponding to the length of the bony bridge which one was about to form. Over the flap which has been turned down from the forehead the soft parts are united. Dr. Lange said the method was similar to others which had been devised for this purpose, especially that by Wolf, who leaves the flap covered with the entire thickness of the integument, consequently making the bridge of the nose easily too high and leaving no indentation where one normally exists, at the os frontis. The patient who was presented had once been submitted to a procedure which had been recommended by Dr. Weir a year previously; that is, she had worn a platinum frame or support to the soft parts for about a year, but had to discard it on account of discomfort and ulceration. The operation performed by Dr. Lange was a comparatively simple one, and when no ulceration took place, would, he thought, offer a lasting result. In the present instance a small piece of the lower end of the bony flap ulcerated and came away, leaving a slight depression near the tip of the nose. Dr. Lange had resorted to this procedure in one other case in which there had been destruction of bone, cartilage and soft parts to such an extent that the small rudiment of the nose was depressed into the nasal cavity and the periosteal layer had to be imbedded between the soft flaps, which had been formed from the soft parts. In that case, also, there had been some ulceration, perhaps in consequence of chiseling into the frontal sinus, and some spiculæ came out, but so far as the bony bridge of the nose was concerned the result had been very satisfactory.

FOREIGN BODIES IN THE APPENDIX VERMIFORMIS.

Dr. F. H. MARKOE presented specimens of foreign bodies from the appendix vermiformis in two cases, the body being in one instance a black pin, in the other a fæcal concretion of considerable size. The latter specimen was found in the case of a prize fighter who had only three days before "fought a fight to the finish," as he expressed it. He had never before had an attack of appendicitis. The operation was done on the third day. The appendix lay behind the cæcum, and the gangrenous patch at the site of perforation was close to its proximal end.

RENAL CALCULUS, NEPHROTOMY.

Dr. L. A. STIMSON presented a heart-shaped renal calculus, measuring an inch in its greatest diameter, having a rough surface, the roughness being particularly marked at one end by pointed and laminated crystals. It had been removed from a lad of seventeen years who had suffered five years with a dull, constant pain in the left loin. In May, 1892, after exposure to wet, cold and fatigue, the pain became very severe, and was followed by chill and the appearance of blood in the urine. His physician diagnosed acute Bright's disease, and there was a large amount of albumin and also tube casts in the urine, which seemed to justify the diagnosis. He remained under treatment until the latter part of July of this year, when he came under Dr. Stimson's care. The history seemed to point to calculus of the kidney—pain, blood in the urine, exacerbations on exercise. But no enlargement of the kidney could be felt. He made a diagnosis of pyelitis with probable calculus, and advised an operation, which was performed about the first of August. The kidney was freely exposed and appeared normal. A round needle was introduced, the stone was felt, the kidney was then divided along its convexity with the Paquelin cautery, the foreign body was removed and the patient made an uneventful recovery, the wound being healed in three weeks.